Problem behaviour in a Flemish therapeutic centre for children and youth with EBD: group workers, teachers and youth as different informants.

Introduction

Children and adolescents with emotional and behavioural disorders require special treatment programmes which meet their social/emotional needs and address their problems. Specifically, children in residential settings are a highly complex and poorly understood population, often subject to multiple child-service systems including health, child welfare, and special education (Hussey & Guo, 2005). They are a highly vulnerable group and have extensive mental health needs (Hukkanan et al, 1999).

More boys than girls are affected (3:1 or 4:1) (American Psychiatry Association, 1987; Fagot & Leve, 1998; Van der Ploeg & Mooij, 1998). High comorbidity rates are reported for DSM diagnoses of conduct disorder with oppositional disorders, affective disorders, anxiety disorders, and attention deficit disorders (McConaughy & Skiba, 1993; Teplin et al, 2002; Wasserman et al, 2005). The high prevalence and degree of severe disorder in the residential population represents a demanding and difficult burden of treatment and care, which should not be underestimated (Baker et al, 2007).

Findings from a Dutch follow-up research indicate continuity of behavioural and emotional problems in clinically referred children and adolescents, and that these problems should be viewed as chronic conditions (Visser et al, 2003). A recent Flemish research (De Bolle et al, 2009) proved that internalizing and externalizing problem behaviour was almost as stable as personality traits, suggesting that childhood psychopathology is more persistent than generally assumed.

Different informants

When assessing children and youth's problem behaviour, different informants can be used. The decision about what type of person should be the informant and how many informants are necessary usually depends on the context such as the home or school, or the age of the child as an indicator of level of maturity (Rubio-Stipec et al, 2003). Research on informant (dis)agreement is ambiguous. Stanger & Lewis (1993) investigated agreement between mothers, fathers, teachers and children. They found that children generally reported the most problems and teachers the least. Agreement was lowest for rater pairs involving teachers on internalizing problems. Handwerk and his colleagues (1999) on the other hand, found that parents rate the emotional and behavioural problems of their children as more severe than the children did themselves. In looking for agreement between parent, teacher, and male adolescent ratings of externalizing and internalizing problems, Youngstrom, Loeber & Stouthamer-Loeber (2000) proved that both youths and caregivers reported significantly more externalizing problems than teachers. All three informants reported reliably different levels of internalizing problems; youth reported the most, followed by caregivers, with teachers reporting fewer problems. In several researches, agreement between adults and youngsters on externalizing problem behaviour is greater that agreement on internalizing behaviour (Youngstrom, Findling, & Calabrese, 2003; Stanger, 1993; Yeh & Weisz, 2001; Hawley & Weisz, 2003; Epstein et al, 2004; Cai, Kaiser, & Hancock, 2004; Duhig et al, 2000; Grietens et al, 2004; McConaughy et al, 1994; Salbach-Andrae et al, 2009; Andrae, Lenz, & Lehmkuhl, 2009).

Some studies indicate that discrepancies between informants constitute important risk factors for adverse development, since these discrepancies may make it difficult for them to cooperate and actively participate during the treatment process, and influence treatment

processes and outcomes (Ferdinand, van der Ende, & Verhulst, 2004; De Los Reyes, & Kazdin, 2005; Yeh, & Weisz, 2001). On the other hand, results also reinforce the need for multiple sources of information when assessing emotional and behavioural problems in children (Clay, Surgenor, & Frampton, 2008; Ferdinand, van der Ende, & Verhulst, 2004; Ferdinand, van der Ende, & Verhulst, 2006; Youngstrom, Findling, & Calabrese, 2003; Stanger & Lewis, 1993; Youngstrom, Loeber, & Stouthamer-Loeber, 2000; Epstein, et al., 2004; Rubio-Stipec et al., 2003; Comer & Kendall, 2004).

Youth care in Flanders

In Flanders, the Dutch speaking part of Belgium, youth care is divided into three main streams. (1) the school system including special education for children with severe emotional and behavioural disorders; (2) youth protection service with a social and judicial branch for children in problematic educational situations; (3) mental health care for children with a handicap, in this case children with emotional and behavioural disorders. In many youth care services, both education and care are located at the same domain.

The current Flemish referral system selects children with outspoken externalizing and problematic behaviour for special health care and special schools. There seems to be no place for these children in the mainstream schools and primary support systems in Flanders. They are relegated to youth care because the mainstream system is not sufficiently equipped to cope with their disruptive, aggressive behaviour.

A recent research, which involved all placements in six of the seven (semi-) residential centres for emotional and behavioural disorders in East Flanders, shows the complexity and diversity of the needs of these boys and girls (D'Oosterlinck et al., 2006). In the Flemish

mental health care system, there are more boys than girls, mostly placed in residential care. Boys show a low IQ, however, they still score higher than girls, and are more often diagnosed with ADHD, conduct disorders and pervasive developmental disorder. Both boys and girls suffer from comorbidity and most commonly take neuroleptics. Analyses of CBCL (Child Behaviour Checklist) data, filled in by the group workers, revealed that these children and youngsters have a high externalizing and social behavioural profile, show aggressive and delinquent behaviour and suffer from social problems (D'Oosterlinck, 2006).

The aim of our study is twofold. Firstly we want to look at the characteristics of children and youth who are placed in a residential setting for youth with EBD in West Flanders, and / or attend the school for special education which is connected to this centre. Secondly, we want to see if there are specific profiles when using group workers, teachers and youth as different informants.

Method

This research, which took place from March to June 2009, involved all children and adolescents placed in a therapeutic centre for children and youth with EBD in West Flanders and can be seen as part of an extensive research design. Based on previous findings on Life Space Crisis Intervention (LSCI) (D'Oosterlinck et al., 2008; D'Oosterlinck et al., 2009; Soenen et al., 2009), the centre chose to implement this strategy (Long, Wood & Fecser, 2001) as a strategy for conflict management. At the time of this research, the institute offered day treatment, education and residential treatment to 442 children and youngsters with emotional and behavioural disorders and their families.

Prior to the implementation of LSCI, we wanted to investigate the characteristics of the children and youngsters in the centre, and at the specific profiles of these children and youngsters, by using group workers, teachers and youth as different informants.

Data Gathering

File data

Based on the individual files of all youngsters, following data were gathered: age, gender, total intelligence, verbal intelligence, performance intelligence, current type of treatment and diagnostic data. All these data were gathered by psychologists, social workers and pedagogues who are employed at the centre, under supervision of the authors. The human resource department of the centre provided the authors with information on sex, age, and years of experience of all group workers and teachers who work directly with the children and youngsters.

Questionnaires

Subsequently, CBCL, TRF and YSR results were added to the database. The CBCL/6-18 (Child Behaviour Checklist) consists of 118 specific questions concerning emotional and behavioural problems, and two open questions concerning other problems. The answers to these questions lead to different scales. The questions concern behaviour and form together eight problem scales: withdrawn/ depression, somatic complaints, anxiety/depression, social problems, thought problems, attention problems, delinquent behaviour, and aggressive behaviour. The first three problem scales form the broadband scale 'Internalising', and the last two form the broadband scale 'Externalising'. All questions about behaviour together form the scale 'Total problems'. The Dutch version of the CBCL (De Groot, Koot & Verhulst, 1994; Verhulst, van der Ende & Koot, 1996) has proved to be reliable and valid. Although the CBCL was designed to get an image of the problem behaviour of children and youngsters as reported by parents, Albrecht et al. (2001) were able to show that the original CBCL factor model based on parental judgement of child behaviour also fits for the judgement of group care workers. This means that the eight narrow-band syndromes as well as the two broad-band syndromes can be used to interpret the CBCL scores of group care workers. Therefore, a CBCL was filled in for all youths by their individual group worker.

The YSR (for ages 11-18) (Youth Self Report) is a questionnaire in which youngsters themselves score statements about emotional and behavioural problems they experience. Many of these questions are similar to those in the CBCL, supplemented with fourteen socially desirable questions to which most youths answer positively. The YSR includes the same subscales as the CBCL. All children and youngsters were asked to complete a YSR. This took place during class time, under the supervision of one of the authors and a master student Orthopedagogics. The children and adolescents had the opportunity to ask questions about individual items, but were not allowed to seek clarification about how they should

respond. Children and adolescents who were absent, were asked to fill in a YSR after they returned.

The TRF (for ages 6-18) is a questionnaire on which teachers can answer questions regarding schoolwork and emotional and behavioural problems. The TRF consists of 118 questions, from which 93 also appear in the CBCL. The TRF includes the same subscales as the CBCL and the YSR. All class teachers were asked to complete a TRF for each of their students.

Data analysis

File data

The age groups were reduced into two categories: a category with age 6 to 12, and a category with youngsters age 13 to 18. The reason for this distribution is the fact that at 13, children pass from primary school to secondary school. Based on the clinical borderline, intelligence scores were grouped in a category with scores below 70 and a category with scores above 70. The different types of treatment were divided into residential care and day treatment. Due to dated or incomplete data, other diagnostic information was excluded.

The age groups of the group workers and the teachers was reduced to a category of group workers younger than 36 (= mean age) and a category of group workers older than 36. The same was done for years of experience of staff, with a mean of 13 years for group workers and 10 years for teachers.

Questionnaires

Using a One-sample t test, with the clinical cut-off of 60 for the total and broadband scores, and 65 for the narrowband scores as test value, we wanted to test whether mean scores of all

three questionnaires differed from this clinical cut-off score. Next, an independent samples t-test was performed with youths' 'gender', 'age', 'intelligence' and 'treatment type', 'age informant' and 'experience informant' as grouping variable. Finally, ANOVA of repeated measures with Bonferroni correction for multiple comparisons were used to examine the differences in mean scores between informants.

Inspired by the work of D'Oosterlinck et al. (2006), three different profiles were developed; one on the basis of the CBCL, one on the basis of the TRF and one on the basis of the YSR. Correlations (Pearson Correlation Coefficient) between the 'total score' and the two 'broadband syndrome scales' (internalizing, externalizing) were measured for the CBCL, TRF and YSR. The strongest correlation found between 'total score' and the broadband syndrome was correlated with the remaining syndrome scales, and this strongest correlation was withheld. These remaining variables were used to construct the profile.

Results

File data

The sample (n = 434) shows a ratio of boys and girls of 3-1 (71.80% – 28.20%). The majority (65.60%) of them is older than 12, with a mean age of 13.35. About half of the youngsters in the sample are placed in residential care, whilst the other half is offered day treatment. Mean intelligence scores are 77.12 (IQ), 77.96 (VIQ) and 82.16 (PIQ). For gender and age, no significant differences were found on IQ scores. Youth in residential care have a significant lower verbal intelligence (p=0.022) than youth in day treatment.

Table 1: descriptives of data file

	N	Mean	Std. Deviation
Age youngsters	434	13.35	3.17
Verbal IQ	339	77.96	11.62
Performance IQ	339	82.16	11.92
Total IQ	339	77.12	10.16
Age group worker	156	36.28	11.87
Experience group worker	156	12.70	11.42
Age teacher	321	35.60	4.08
Experience teacher	321	9.88	4.07

Table 2: frequencies of data file

		%	N
Age youth	- 12	34.4	149
	+ 12	65.6	284
Sex	Girl	28.2	123
	Boy	71.8	313
Treatment	Residential	46	194
	Day treatment	54	228

Questionnaires

Table 3 shows that mean scores on CBCL ‘externalizing’ (p=.000) and CBCL ‘total’ (p=.020) are significant higher than the clinical cut-off score of 60. Mean scores on CBCL ‘internalizing’ (p=.000), TRF ‘internalizing’ (p=.000), TRF ‘externalizing’ (p=.001), TRF ‘total’ (p=.000), YSR ‘externalizing’ (p=.000) and YSR ‘total’ (p=.025) are significantly lower than the clinical cut-off score of 60. A One-sample t test with a cut-off score of 65 on the narrowband syndrome scales shows that all scores are lower than the clinical cut-off, with the exception of CBCL ‘delinquency’ (p=.443).

Table 3: mean scores & one-sample t test

	Mean	Sig. (2-tailed)	Mean Difference
CBCL internalizing	55.37	,000	-4.62
CBCL externalizing	64.47	,000	4.47
CBCL total	61.75	,020	1.74
TRF internalizing	54.15	,000	-5.84
TRF externalizing	57.93	,001	-2.06
TRF total	56.21	,000	-3.78
YSR internalizing	59.29	,250	-.71
YSR externalizing	57.05	,000	-2.94
YSR total	58.66	,025	-1.34

Group workers scored girls significantly higher on ‘somatic complaints’ than boys, and youth with IQ scores below 70 scored significantly higher than youth with IQ scores above 70 on the syndrome scale ‘attention problems’. No significant differences were found on the CBCL

when using gender or age of the youngster, treatment type, or gender, age and experience of the group worker as grouping variable.

On the TRF, teachers scored girls higher than boys on ‘total score’, ‘anxious/depressed’, ‘somatic complaints’ and ‘social problems’. Children and youth in residential care were scored higher on ‘externalizing’, ‘total score’, ‘aggression’, ‘delinquency’, ‘social problems’, ‘thinking problems’ and ‘attention problems’ than children and youth in day treatment. Female teachers scored their student higher on ‘somatic complaints’. Teachers younger than 36 scored students higher on all scales, while teachers with less than ten years experience on the job scored their students higher on ‘internalizing’, ‘externalizing’, ‘total score’, ‘withdrawn/depressed’, ‘anxious/depressed’, ‘somatic complaints’ and ‘social problems’. No significant differences were found when using ‘age of the youth’ or ‘intelligence’ as independent variable.

When looking at the YSR, girls had higher scores on ‘internalizing’, ‘withdrawn/depressed’, and ‘anxious/depressed’ than boys. Children and youngsters in residential care had higher scores than children and youth in day treatment on all scales except ‘somatic complaints’. Younger children had higher scores than older children on ‘internalizing’, ‘somatic complaints’, ‘social problems’, and ‘thinking problems’. When using intelligence as a grouping variable, results show that youth with a TIQ above 70 have higher scores than youth with a TIQ below 70 on the broadband scale ‘internalizing’ and on the narrowband scale ‘somatic complaints’.

Further, an ANOVA of repeated measures with Bonferroni correction for multiple comparisons was used to examine the differences in mean scores between informants (table 4). Results of this test indicate that problem behaviour on the internalizing broadband scale is scored higher by children and youngsters themselves than it is by group workers or teachers.

On the externalizing scale, mean scores of the CBCL were significantly higher than mean scores on the TRF or on the YSR. Total scores of the CBCL are significantly higher than on the TRF and the YSR, whilst total scores on the YSR are higher than total scores on the TRF.

Figure 1

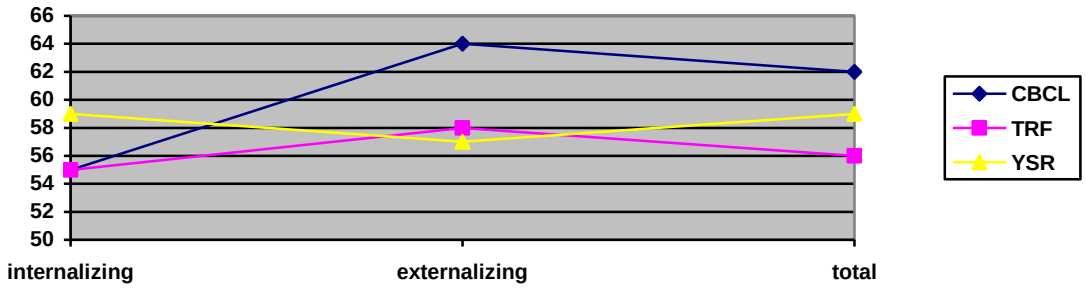

Table 4

Dependent Variable	(I) informant	(J) informant	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Upper Bound	Lower Bound
intern	cbcl Mean 55.37	trf	1.21932	.92966	.570	-1.0115	3.4501
		ysr	-3.91360(*)	.96491	.000	-6.2289	-1.5983
	trf Mean 54.15	cbcl	-1.21932	.92966	.570	-3.4501	1.0115
		ysr	-5.13292(*)	.80864	.000	-7.0733	-3.1926
	ysr Mean 59.29	cbcl	3.91360(*)	.96491	.000	1.5983	6.2289
		trf	5.13292(*)	.80864	.000	3.1926	7.0733
extern	Cbcl Mean 64.47	trf	6.53595(*)	.99073	.000	4.1586	8.9132
		ysr	7.41715(*)	1.02829	.000	4.9497	9.8846
	trf Mean 57.94	cbcl	-6.53595(*)	.99073	.000	-8.9132	-4.1586
		ysr	.88120	.86175	.921	-1.1866	2.9490
	Ysr Mean 57.05	cbcl	-7.41715(*)	1.02829	.000	-9.8846	-4.9497
		trf	-.88120	.86175	.921	-2.9490	1.1866
total	Cbcl Mean 61.75	trf	5.53448(*)	.92286	.000	3.3200	7.7489
		ysr	3.08652(*)	.95785	.004	.7881	5.3849
	trf Mean 56.21	cbcl	-5.53448(*)	.92286	.000	-7.7489	-3.3200
		ysr	-2.44796(*)	.80272	.007	-4.3741	-.5218
	Ysr Mean 58.66	cbcl	-3.08652(*)	.95785	.004	-5.3849	-.7881
		trf	2.44796(*)	.80272	.007	.5218	4.3741
withdrawn	cbcl Mean 60.37	trf	4.25783(*)	.72817	.000	2.5106	6.0051
		ysr	1.37430	.75578	.208	-.4392	3.1878
	trf Mean 56.11	cbcl	-4.25783(*)	.72817	.000	-6.0051	-2.5106
		ysr	-2.88353(*)	.63338	.000	-4.4033	-1.3637
	Ysr Mean 58.99	cbcl	-1.37430	.75578	.208	-3.1878	.4392
		trf	2.88353(*)	.63338	.000	1.3637	4.4033

anxious	Cbcl	trf	1,42718	.75399	.176	-.3821	3.2364
	Mean 57.25	ysr	-2.17279(*)	.78258	.017	-4.0506	-.2950
	Trf	cbcl	-1.42718	.75399	.176	-3.2364	.3821
	Mean 55.83	ysr	-3.59997(*)	.65584	.000	-5.1737	-2.0263
	Ysr	cbcl	2.17279(*)	.78258	.017	.2950	4.0506
	Mean 59.43	trf	3.59997(*)	.65584	.000	2.0263	5.1737
somatic	Cbcl	trf	.03262	.70194	1.000	-1.6517	1.7170
	Mean 53.20	ysr	-6.63654(*)	.72855	.000	-8.3847	-4.8884
	Trf	cbcl	-.03262	.70194	1.000	-1.7170	1.6517
	Mean 53.17	ysr	-6..66916(*)	.61056	.000	-8.1342	-5.2041
	Ysr	cbcl	6.63654(*)	.72855	.000	4.8884	8.3847
	Mean 59.84	trf	6.66916(*)	.61056	.000	5.2041	8.1342
aggression	Cbcl	trf	4.87423(*)	.80506	.000	2.9425	6.8060
	Mean 63.60	ysr	4.54137(*)	.83558	.000	2.5364	6.5464
	Trf	cbcl	-4.87423(*)	.80506	.000	-6.8060	-2.9425
	Mean 58.72	ysr	-.33286	.70026	1.000	-2.0131	1.3474
	Ysr	cbcl	-4.54137(*)	.83558	.000	-6.5464	-2.5364
	Mean 59.05	trf	.33286	.70026	1.000	-1.3474	2.0131
delinquency	Cbcl	trf	5.85026(*)	.90031	.000	3.6899	8.0106
	Mean 65.65	ysr	7.98159(*)	.93444	.000	5.7394	10.2238
	Trf	cbcl	-5.85026(*)	.90031	.000	-8.0106	-3.6899
	Mean 59.80	ysr	2.13133(*)	.78311	.020	.2522	4.0104
	Ysr	cbcl	-7.98159(*)	.93444	.000	-10.2238	-5.7394
	Mean 57.67	trf	-2.13133(*)	.78311	.020	-4.0104	-.2522
social	Cbcl	trf	3.84904(*)	.74638	.000	2.0581	5.6400
	Mean 61.75	ysr	1.77745	.77456	.066	-.0812	3.6361
	Trf	cbcl	-3.84904(*)	.74638	.000	-5.6400	-2.0581
	Mean 57.90	ysr	-2.07159(*)	.64788	.004	-3.6262	-.5170
	Ysr	cbcl	-1.77745	.77456	.066	-3.6361	.0812
	Mean 59.97	trf	2.07159(*)	.64788	.004	.5170	3.6262
thinking	Cbcl	trf	2.09720(*)	.73681	.014	.3292	3.8652
	Mean 56.23	ysr	-1,53578	.76463	.135	-3.3706	.2990
	Trf	cbcl	-209720(*)	.73681	.014	-3.8652	-.3292
	Mean 54.13	ysr	-363299(*)	.63957	.000	-5.1677	-2.0983
	Ysr	cbcl	153578	.76463	.135	-.2990	3,3706
	Mean 57.76	trf	363299(*)	.63957	.000	2.0983	5.1677
attention	Cbcl	trf	6.36090(*)	.71633	.000	4.6420	8.0798
	Mean 61.86	ysr	3.66250(*)	.74337	.000	1.8787	5.4463
	Trf	cbcl	-6.36090(*)	.71633	.000	-8.0798	-4.6420
	Mean 55.50	ysr	-2.69840(*)	.62179	.000	-4.1904	-1.2064
	Ysr	cbcl	-3.66250(*)	.74337	.000	-5.4463	-1.8787
	Mean 58.20	trf	2.69840(*)	.62179	.000	1.2064	4.1904

Correlations between CBCL & TRF at the 0.01 level

The total CBCL score correlates with the total TRF score (r=.315; p=.001). On the broadband scales no correlations were found. With regard to the syndrome scales, correlations were

found only for ‘withdrawn’ (r=.347; p=.000), ‘aggression’ (r=.356; p=.000), and ‘delinquency’ (r=.401; p=.000).

Correlations between CBCL & YSR at the 0.01 level

Only for the broadband scale ‘externalizing’ a correlation was found (r=.306; p=.005). The syndrome scales which correlate are ‘aggression’ (r=.433; p=.000) and ‘anxious/depressed’ (r=.343; p=.002).

Correlations between TRF & YSR at the 0.01 level

For the TRF and the YSR, correlations were found for all scales. Correlations were stronger for externalizing behaviour (r= .502, p=.000) than they were for internalizing behaviour (r=.274, p=.000).

Behaviour profile

Using Pearson correlations, a profile was developed for all youth, based on data from each informant. Correlations between the ‘total score’ and the two ‘broadband syndrome scales’ (‘internalizing’, ‘externalizing’) were measured for the CBCL, TRF and YSR. The strongest correlation found between ‘total score’ and the broadband syndrome was correlated with the remaining syndrome scales, and this strongest correlation was withheld.

Behaviour profile with the group worker as informant

The strongest correlation was found between ‘total’ and the broadband syndrome ‘externalizing’ (r=.872, p=.000). When comparing ‘externalizing’ with the six remaining syndrome scales (‘withdrawn/depressed’, ‘anxious/depressed’, ‘somatic complaints’, ‘social problems’, ‘thinking problems’, and ‘attention problems’), the correlation with the syndrome scale ‘attention problems’ was the strongest (r=.559, p=.000). In order to clarify these correlations, a cross table was compiled, with each variable divided into two groups: clinical or not clinical. This led to the profile ‘externalizing-attention problems’ (EA), based on questionnaires with the group worker as informant (table 5). This construction leads to three groups:

1. low EA-profile: youth with scores within the normal range for both ‘externalizing’ as ‘attention problems’ (n= 45; 28.1%)
2. intermediate EA-profile: youth with clinical scores for either ‘externalizing’ or ‘attention problems’ (n= 63; 39.4%)
3. high EA-profile: youth with scores within the clinical range for both ‘externalizing’ as ‘attention problems’ (n= 52; 32.5%)

Table 5

			Cbcl attention problems	
			normal	clinical and subclinical
Cbcl externalizing	normal	Count	45	8
		% of Total	28.1%	5.0%
	clinical	Count	55	52
		% of Total	34.4%	32.5%

When selecting the data on gender of the youth, age and experience of the group worker, the profile is the same. When the group worker is male, when the youngsters are younger than 12, or when the youngster have an IQ below 70; the profile based on the CBCL is ‘externalizing-social problems’.

Behaviour profile with the teacher as informant

When correlating the broadband scales with the total score of the TRF, the strongest correlation was found between ‘total’ and ‘externalizing’ (r=.889, p=.000). When correlating ‘externalizing’ with the remaining syndromes scales, the correlation was strongest with ‘attention problems’ (r=.757, p=.000). Similar as with the CBCL, these correlations lead to the profile ‘externalizing-attention problems’ (AE) (table 6).

1. low EA-profile: youth with scores within the normal range for both ‘externalizing’ as ‘attention problems’ (n= 166; 53.0%)
2. intermediate EA-profile: youth with clinical scores for either ‘externalizing’ or ‘attention problems’ (n= 114; 36.4%)
3. high EA-profile: youth with scores within the clinical range for both ‘externalizing’ as ‘attention problems’ (n= 33; 10.5%)

Table 6

			Trf attention problems	
			normal	clinical and subclinical
Trf externalizing	normal	Count	166	1
		% of Total	53.0%	0.3%
	clinical	Count	113	33
		% of Total	36.1%	10.5%

The profile ‘externalizing-attention problems’ remained applicable when controlling for age, gender and IQ of the youth, and for age, experience and sex of the teacher.

Behaviour profile with the children and adolescents as informant

In contrast with the CBCL and the TRF, the correlation on the YSR between ‘total’ and the broadband scales was strongest with ‘internalizing’ (r=.838, p=.000). ‘Internalizing’ correlated strongest with the syndrome scale ‘thinking problems’ (r=.696, p=.000), which results in the profile ‘internalizing-thinking problems’ (IT) (table 7) when the youth himself is the informant.

1. low IT-profile: youth with scores within the normal range for both ‘internalizing as ‘thinking problems’ (n= 129; 50.6%)
2. intermediate IT-profile: youth with clinical scores for either ‘internalizing or ‘thinking problems’ (n= 89; 34.9%)
3. high IT-profile: youth with scores within the clinical range for both ‘internalizing as ‘thinking problems’ (n= 37; 14.5%)

Table 7

			Ysr thinking problems	
			normal	clinical and subclinical
Ysr internalizing	normal	Count	129	4
		% of Total	50.6%	1.6%
	clinical	Count	85	37
		% of Total	33.3%	14.5%

The profile remained applicable when controlling for treatment type. When controlling for sex and IQ, boys and youth with an IQ score below 70 had the profile ‘internalizing-social problems’. Children younger than 12 had the profile ‘externalizing-social problems’.

Discussion

The group of children and youngsters in our sample show a boy-girl ratio of 3-1. About half of the sample is in residential care, while the others are in day treatment. The average IQ of youth in our sample is about 25 points below the normal range, but also 10 points below results of comparable research in Flanders (D'Oosterlinck et al., 2006). A possible explanation could be found in the historical context of the centre. While nowadays the primary focus of the centre is on treatment for youth with emotional and behavioural disorders, in the past the focus was on treatment for youth with mild mental disability.

On the YSR, girls had higher scores on 'internalizing', 'withdrawn/depressed', and 'anxious/depressed' than boys did. Scores were higher for girls on 'somatic complaints' when using the CBCL, and on 'total score', 'anxious/depressed', 'somatic complaints' and 'social problems' when using the TRF. No significant gender differences were found on the externalizing scales. These findings correspond with other studies (Handwerk & Marshall, 1998; Slobodskaya, 1999; Sohn, 2003; Wasserman et al., 2005), although some have found higher scores on the internalizing scale for boys than for girls (Brady & Caraway, 2002).

Youth themselves score higher on the internalizing scales than adults do. Correlations between youth and adults were also stronger for externalizing behaviour than they were for internalizing behaviour. When using data from group workers, teachers and youth as different informants to develop a behaviour profile, results show a similar tendency. The profile constructed using the CBCL or the TRF indicates that youth in our sample show aggressive and delinquent behaviour and suffer from attention problems (externalizing – attention problems profile). On the other hand, the profile constructed using the YSR indicates that

youth are withdrawn, anxious/depressed, have somatic complaints and suffer from thinking problems (internalizing – thinking problems profile).

Our findings correspond with several other studies, which have shown that disagreement between youth and their caregivers is low for internalizing problems (Stanger & Lewis, 1993; McConaughy, Mattison, & Peterson, 1994; Youngstrom, Loeber, & Stouthamer-Loeber, 2000; Hawley & Weisz, 2003; Grietens et al., 2004; Andrae, Lenz, & Lohaus, 2009; Salbach-Andrae et al., 2009) and that internalizing scores on self reports are higher than on reports of caregivers. (Youngstrom, Loeber, & Stouthamer-Loeber, 2000). Together with others, our explanation for these discrepancies lies in the assumption that externalizing problems are more easily observed and more disturbing than internalizing problems (McConaughy & Skiba, 1993; Mesman & Koot, 2000). Subsequently, children may see internalizing behaviours as salient serious problems that are thus more likely to be perceived and reported by the children, since these problems cause them distress (Karver, 2006).

We want to stress that these common found discrepancies between different informants should never evolve into a discussion about whose perception is right and whose is wrong. The discrepancies do not necessarily imply a distortion, but rather reflect the complex nature of a child and his or her problems, as it is presented and experienced in different realities. Nevertheless, we agree with authors who state that discrepancies between informants may hinder the abilities of informants to participate in treatment and to work together on the goals of treatment (Yeh & Weisz, 2001; Hawley & Weisz, 2003; De Los Reyes & Kazdin, 2005).

Therefore, we underscore the common assumption that information from different informants is needed in clinical practice (Stanger & Lewis, 1993; Barbosa, Tannock, & Manassis, 2002; Rubio-Stipec et al, 2003; Epstein et al., 2004; Silverman & Ollendick, 2005; Vierhaus & Lohaus, 2008).

A remarkable finding worth mentioning is the difference in correlations between YSR and TRF on one hand, and YSR and CBCL on the other hand. While only few correlations are found between YSR and CBCL ('externalizing', 'aggression', 'anxious/depressed'), for the TRF and the YSR, correlations were found on all scales. A possible explanation could be found in the context in which teachers and group workers work with children and youngsters. A classroom is a structured environment with approximately 8 students and one teacher. This setting is characterized by clear expectations, but also offers students a safe environment and multiple opportunities to express their inner mental state. In living groups on the other hand, up to 14 children live together in a less structured environment. Taken into account the complexity of the problems youth in Flemish therapeutic centres, we believe that especially the size of the living groups may create a barrier for youth and group workers to interact in a safe and treatment-oriented way. If the Flemish government want therapeutic centres to work effectively with their youth in groups, more funding has to be provided in order to reduce group sizes and use individualized educational and learning approaches which can be integrated within the Flemish tradition of 'the group as method'.

Finally, it is important to stress the main limitations of our study.

First, although the narrow-band syndromes as well as the 2 broad-band syndromes can be used to interpret the CBCL scores of group care workers, the CBCL was originally designed to be filled in by parents instead of group workers. Therefore, it would have been useful involve parents as informants.

Secondly, all data were gathered in one therapeutic centre. Although the centre represents the majority of care for youth with emotional and behavioural disorders in the West Flanders, generalization of results should be interpreted carefully.

Finally, due to pragmatic reasons, only three different questionnaires were used in this study. It would be a simplification to reduce problem behaviour of youth in Flemish care to the scores, correlations and profiles resulting from only these questionnaires.

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